Estimated Revenue Losses Soar for New ESOP Provision

Estimates of revenue losses from a new employee stock ownership plan (ESOP) provision included in the 1986 Tax Reform Act have soared from an originally estimated $50 million to as high as $20 billion over the next five years. In an attempt to control revenue losses from this provision, the Internal Revenue (IRS) issued a notice seeking to limit the scope of this provision on January 5. In addition, corrective legislation is being considered.

Section 2057 of the Internal Revenue Code, added by the 1986 Tax Reform Act, provides a deduction for estate tax purposes of an amount equal to 50 percent of the proceeds obtained from a sale of employer securities to an ESOP or eligible worker-owned cooperative. The vastly increased estimates of revenue loss from this provision are based on the assumption that the provision could be used, under expansive interpretations, to virtually eliminate estate taxes. The provision, however, was targeted as a technical flaw in a January 5 letter from Joint Tax Committee Staff Director David Brockway to chairmen of the House and Senate tax-writing committees, and remedial legislation is anticipated to block the more ambitious interpretations of section 2057.

As drafted, section 2057 provides that an estate is entitled to a deduction equal to 50 percent of the proceeds from a sale of company stock to that company's ESOP. To obtain the deduction, the sale must take place after the enactment of the 1986 Tax Reform Act, and the estate must receive the proceeds from the sale before the date on which the federal estate tax return is required to be filed (including any extensions). The provision would not apply to sales made after December 31, 1991. The following restrictions are also applicable under the statutory language:

1. No estate tax deduction is available for the sale of securities which were received from a qualified pension, profit sharing, or stock bonus plan or pursuant to certain options or other rights to acquire stock.

2. The company whose stock is sold to the ESOP must sign a written statement consenting to the application of Code section 4979(a). That section provides for a 50 percent excise tax on the company if stock acquired from an estate pursuant to section 2057 is allocated by the ESOP to or for the benefit of the decedent whose estate made the sale, certain individuals related to that decedent, or other individuals who own directly (or by attribution) more than 25 percent of any class of the company stock.

3. The stock must be common stock or noncallable preferred stock, which is readily convertible into common stock.

In 1987, the maximum federal estate tax rate, applicable to taxable estates in excess of $3 million, is 55 percent. For an estate taxable at this rate, the net value to the estate of $1 million (market value) of employer stock is $450,000 ($1 million market value less $550,000 estate tax). If the estate sells this stock to an ESOP for its market value, the estate would obtain a $500,000 estate tax deduction and the value of the securities to the estate would be increased from $450,000 to $725,000 ($1 million market value less $275,000 estate tax).

Because of the size of the estate tax advantage, the value of stock to an estate could be significantly increased, even if the stock is sold to an ESOP at a price substantially below market. For example, stock with a market value of $1 million might be sold to an ESOP for $850,000. The tax savings from such a sale would be at least $233,750, so that the net value of the estate would be increased by $83,750 (from $450,000 to $533,750).

The estimated revenue loss from sales by estates to ESOPs has been estimated to be as much as $20 billion over the next five years. This estimate is based on the assumption that nearly all estate tax revenues will be eliminated. The virtual elimination of estate taxes would be possible, however, only if estates were able to buy stock after death occurs and sell it to ESOPs until they reach the point at which estate taxes are eliminated. To block this result, the IRS...
announced in Advance Notice 87-13, released on January 5, 1987, that it would not recognize a deduction under 4975 unless "the decedent directly owned the employer securities immediately before death and after the sale, the employer securities are allocated to participants or are held for future allocation" (answer no. 23, Advance Notice 87-13, Internal Revenue Bulletin (IRB) 1987-4, January 26, 1987).

Some practitioners contend there is little basis for the IRS-promulgated restrictions in the statutory language enacted last year. Nonetheless, the restrictions could be upheld by the courts, and some form of restriction is likely to be enacted by Congress in any event.

Assuming implementation of the proposed IRS restrictions, section 2057 will still offer dramatic opportunities for estates to reduce their estate taxes and for ESOPs to acquire employee stock at bargain prices. Presumably, if a sale qualifies under section 2057, the tax savings will be shared, allowing an ESOP to purchase stock at a price significantly below market value while still increasing the net value of the estate due to the reduction in estate taxes.

A number of questions arising under this new provision are still unanswered. For example, if an estate sells stock with a market value of $1 million for $800,000 to an ESOP, will the $800,000 sales price or the $1 million market value be included in the taxable estate? A literal interpretation of the statute suggests that the $800,000 value should be used if the sale takes place before the alternate valuation date and the estate elects to use the alternate valuation date. On the other hand, if the sale is for $800,000 and the stock is valued at $1 million for estate tax purposes, the sale would seem to give rise to a $200,000 capital loss which would further increase revenue losses.

[Editor's Note: This article was prepared by the law firm of Arnold & Porter, EBRI's counsel, and is a regular feature of Employee Benefit Notes.]

**Federal Qualification of HMOs and Employer Choice**

Health maintenance organizations (HMOs) have grown rapidly in recent years as employers have sought to control health care costs. By offering a comprehensive set of health services in exchange for a fixed, prepaid fee, HMOs have stronger incentives to constrain health service use than do traditional fee-for-service insurance plans. Research has shown that total medical costs under an HMO are less than those covered on a first-dollar basis. But because employers are imposing more cost-containment requirements on their traditionally insured employees, HMOs have come under scrutiny as well.

"Federally qualified" HMOs are subject to federal regulation under the Health Maintenance Organization Act of 1973. The HMO act specifies the minimum services federally qualified HMOs must cover and requires that they "community rate" premiums. Federally qualified plans must meet certain standards to assure financial solvency, and are required to use certain quality-assurance mechanisms.

HMOs derive a major benefit by obtaining federal qualification. The act requires that any employer providing health insurance coverage to more than 25 employees offer employees the choice of enrolling in a federally qualified HMO if the employer is requested by an HMO to do so. The employer must then provide a per-employee contribution to HMO coverage equal to its contribution toward its standard insurance coverage. In addition, federal qualification is sometimes perceived as a "seal of approval." HMOs that are not federally qualified are subject only to state regulation, but are denied the benefits of the HMO act.

In the increasingly competitive market for health care, federal regulatory requirements may restrict employers' ability to negotiate health plans' service coverage and cost. The employer may not wish to cover some HMO services required by the act. The requirement that federally qualified HMOs community rate premiums means that employers with a mix of workers different from the community norm are not able to negotiate a premium reflecting the experience of their workforce.

The HMO act came up for renewal during the 99th Congress and passed without major changes. The administration, however, had proposed to repeal the act entirely, and legislation to amend the HMO act may resurface in the 100th Congress. Changes in the act or in the regulations implementing the act may alter incentives for HMOs to seek federal qualification. Non-federally qualified HMOs, which have more latitude to compete for employer contracts by changing their covered services and the premiums they charge, may consequently grow. Proposed regulations by the Health Care Financing Administration, for example, would eliminate the requirement that an employer must contribute equally to coverage under a federally qualified HMO and under a conventional insurance plan. Congressional staff, however, predict rough sledding for the administration's proposal. (See the "Congressional Staff Outline Health Agenda," this issue. Also see the January 13, 1987, Federal Register, vol. 52, no. 8, pp. 1343-1344, and January 1987 Employee Benefit Notes).
percent of federally qualified HMOs.

For-profit HMOs have grown rapidly in recent years and, like other profit-making enterprises in health care, are controversial. The majority of all operating HMOs are for-profit (60 percent), although nonprofit HMOs have the largest share of enrollees. New HMOs (in operation one year or less) are more likely to be for-profit, and nonqualified HMOs are more likely than qualified HMOs to be for-profit (chart 3). Among older HMOs, however, the proportions are reversed. Federally qualified plans in existence longer than one year are more likely to be for-profit than are nonqualified plans of similar age.

Differences in operating characteristics of HMOs are at the discretion of the HMO management, as is the decision to seek federal qualification. Changing the HMO act—and consequently, the competitive advantages of compliance with the act—would in turn affect the choices employers make in the range of health coverage options offered to their employees.

In its 1986 June Update, InterStudy, Inc. indicates that as of June 1986 slightly more than half, or 302 of 595 operating HMOs, were federally qualified. Among HMOs that had been operating for more than one year, 68 percent were federally qualified. Federally qualified HMOs held an 82 percent share of enrollment, with 19.3 million of the total 23.7 million persons enrolled in HMOs. Federally qualified HMOs thus tend to be larger than nonqualified HMOs (chart 1), particularly among plans in operation for more than one year.

Four HMO Models

The Interstudy report distinguishes four HMO models. The individual practice association (IPA) model contracts with individual physicians practicing in their own offices to provide care to HMO patients; IPA physicians may continue to see private patients in addition to HMO members. Group model HMOs contract for physician services with a single, large, independent physician group practice. Staff model HMOs employ physicians who, therefore, are closely tied to the management of the HMO. The network model HMO is a hybrid that contracts with several physician groups.

IPAs are the most numerous and rapidly growing HMO model, and are even more common among nonqualified HMOs than among federally qualified HMOs (chart 2). Of all nonqualified HMOs, 70 percent were IPAs, compared with 46 percent of federally qualified HMOs.
Chart 3
Distribution of Federally Qualified HMOs by Plan Age and Profitmaking Status

- 33.6% For-profit, more than 1 year old
- 4.3% Nonprofit, more than 1 year old
- 24.2% For-profit, 1 year old or less
- 37.9% Nonprofit, 1 year old or less


Distribution of Nonqualified HMOs by Plan Age and Profitmaking Status

- 21.5% For-profit, more than 1 year old
- 13.4% Nonprofit, more than 1 year old
- 47.9% For-profit, 1 year old or less
- 17.2% Nonprofit, 1 year old or less

Reciprocity and Multiemployer Funds: A Model of Portability

[Editor's Note: The following article was contributed by the Martin E. Segal Company. For more on portability, see the July 1986 EBRI Issue Brief and March and October 1986 Employee Benefit Notes.]

Multiemployer pension and welfare funds, by their very nature, provide partial portability of benefits. Employees participating in a multiemployer plan continue to accrue benefits as they move from one participating employer to another. Employees covered by a multiemployer fund, however, may still legally lose benefits if they go to work for an employer that participates in another fund.

Reciprocity agreements were first developed in the mid-1960's by multiemployer funds to further expand the opportunity for employees to retain health and welfare benefits and receive a pension when their employment is divided among employers contributing to different multiemployer funds. Thus, reciprocity may be considered portability between funds—an extension of the portability multiemployer funds enjoy between employers in a single fund—by a mutual exchange of privileges or rights. Reciprocal agreements can be developed for pension or welfare funds.

It should be noted at the outset that many reciprocal agreements were established prior to ERISA. For those arrangements established after 1974, there is nothing in ERISA that specifically regulates reciprocity agreements beyond requiring that reciprocity agreements must not operate in such a manner as to cause or result in violations of law.

Today, nearly half of all multiemployer funds are party to some form of reciprocity agreement. They are most common, however, in the building and construction trades industry due to its very mobile work force.

Reciprocity and Pension Funds

The primary objective of a reciprocity agreement between two or more pension funds is to prevent the permanent loss of pension credits for plan participants when they switch employment. Although other reciprocal arrangements are possible, the two systems most widely used for pension funds are pro rata reciprocity and "money-follows-the-man."

Under a pro rata pension arrangement no money is transferred between funds. Instead, pension credits are maintained by each fund and upon retirement a partial, or pro rata, benefit is paid by each pension fund, based on the pension credits earned with that fund. Vested status and/or pension eligibility, however, are calculated based on the credits earned under all participating funds.

There are three primary advantages of this type of reciprocity. First, it requires no special correspondence or financial accounting between funds, except at the point of retirement. Next, a pro rata system of reciprocity can easily accommodate plans with vastly different benefit structures or contribution levels. Third, it allows for equitable allocation of the costs of the benefit; each fund carries its pro rata share.

The money-follows-the-man approach to reciprocity assigns each employee to a "home" fund. When an employee works outside the jurisdiction of the home fund, the actual monetary contributions that are made to the local area fund are transferred to the home fund. At retirement, the home fund pays the entire pension in accordance with its own benefit formula. When participating funds maintain different contribution levels, the home fund may experience contribution gains or losses, depending upon its own contribution rate relative to the other funds.

This type of reciprocal agreement has the advantage of easy determination of the actuarial liability for split-service employees. In addition, under a money-follows-the-man system, it is relatively simple to calculate an employee's accrued pension at any point, because all of the information is maintained by the home fund. Similarly, processing and paying a monthly pension is simplified because there is only one pension and one pension fund involved. There is also a greater likelihood that employees will qualify for death or other ancillary benefits under the pension plan because the participant qualifies for all benefits offered by the home fund as if the participant had spent an entire career under the home fund.

Reciprocity and Health and Welfare Funds

Because health and welfare funds have shorter eligibility requirements than pension funds, reciprocity agreements between health and welfare funds seek to avoid periods of noncoverage for employees, while they work to establish eligibility under the new fund. The two most common types of reciprocity agreements among welfare funds are money-follows-the-man and "point-of-claim."

As with pension funds, under money-follows-the-man reciprocity agreements between health and welfare funds, a home fund is identified for each employee. Contributions made on the
employee's behalf are sent by the welfare fund in whose jurisdiction the employee is working at any given time, back to the home fund. These contributions are then converted into credit for continuing coverage and all claims by the covered participant are then made against the home fund and paid by the home fund in accordance with its schedule of benefits.

This system of reciprocity for health and welfare funds involves additional bookkeeping and accounting work. And, with health and welfare plans more so than pension plans, the disparity in benefit levels, and thus contribution rates in participating plans, could produce gains or losses for the home fund.

Under point-of-claim reciprocity arrangements, employees are also assigned to a home fund. With this system, however, nothing is actually done until a claim is made to the fund in whose jurisdiction the individual is working and turned down because of lack of eligibility. At this point, if the hours worked under other funds combined with hours worked in the home fund meet the eligibility requirements of the current fund, the claim is paid. This process may require the transfer of contributions in some cases.

This type of reciprocity, like a pro rata system for pension funds, has the advantage of requiring a minimal transfer of any contributions and necessitates only limited bookkeeping and correspondence.

Open-Ended Agreements

Many reciprocal agreements are limited to two geographically neighboring funds. This creates the need for negotiation of a new agreement, or revision of an existing agreement, every time a new fund wants to participate. This situation can be alleviated by an open-ended, or national, reciprocal agreement.

The open-ended agreement works in the following manner: a single, uniform document is prepared at the national level. Each fund that then signs the document automatically has an agreement with every other fund which has signed or will sign in the future. It should be noted, however, that no fund accepts or is responsible for the liability of any other participating fund under an open-ended arrangement.

Costs

Reciprocity arrangements result in a larger number of employees eventually—and actually—receiving pension and health and welfare benefits. Inevitably, this means higher costs to plans. How much higher depends entirely on each individual plan's turnover experience and what benefit provisions are given reciprocal status. The costs may be negligible—under one percent—or they may be substantial—perhaps as high as twenty percent. On average, however, participation in a reciprocal agreement adds an additional three to six percent to the cost of the plan.

Some of the actuarial costs and considerations associated with reciprocal agreements include:
—A contraction in the available employment in one of the participating funds will cause employees to seek jobs in areas covered by the other participating funds. As a result, a large portion of these apparent terminations cannot really be regarded as turnover because there is no release of liability for future benefits.
—The adoption of a reciprocal agreement after a plan has been in existence for some time may create a large liability for this original plan with respect to employees who transfer to another participating fund but had accumulated credits under the original fund for which they might not have been vested, absent the reciprocity agreement. Years of turnover gains (i.e., contributions for workers who do not vest) may be negated by experience in the reciprocity agreement.

—What the amount of movement—both in and out of the fund—is expected to be in the future.

—The cost of administration under a reciprocal agreement depends upon the type of arrangement implemented. While most existing administrative procedures, such as maintaining records and processing applications, will not need to be revised, additional procedures may be needed. The money-follows-the-man approach is frequently the most expensive arrangement, because of the need for the continual movement of money and continuous exchange of information required by this system.

Reciprocal Agreements and Shorter Vesting Requirements

When reciprocal arrangements were first being developed, 15 years or more was the typical length of time an employee was required to work to become vested. The 1974 passage of ERISA with its mandatory ten-year vesting provision somewhat slowed the spread of pension reciprocal agreements, but helped draw attention to health and welfare funds. Enactment of the Tax Reform Act of 1986 brought—for nonmultiemployer plans—a new, more liberal five-year vesting requirement. There is some feeling that improved, i.e., shorter vesting provisions in plans are the most effective way to protect pension rights and achieve the benefits of portability. Improved vesting, however, whether required by statute or implemented voluntarily, does not completely fulfill
the needs otherwise met by pension reciprocal agreements and ignores welfare benefits altogether. These reciprocal arrangements can provide pension benefits for as little as one year of service with a single employer and no waiting period for welfare benefits. They can achieve full portability while maintaining the integrity of individual pension and welfare plans.

After 20-plus years of successful operation on both the local and national level, reciprocity agreements offer valuable insights into an effective and time-proven method of protecting the pension and health and welfare benefits of plan participants.

**Welfare Benefit Nondiscrimination Rules**

[Editor's Note: The following was prepared by Harry Conaway, associate tax legislative counsel with the Department of the Treasury, and Kent Mason, a legislation attorney with the Joint Committee on Taxation. The views expressed in this paper represent their personal views, and not those of the Treasury Department or the Joint Committee on Taxation.]

While not intended as a detailed summary of the welfare benefit nondiscrimination rules, the following is intended to describe the basic structure of and policy rationale for the rules.

**Policy Objective**

A general objective of tax policy, as it relates to an income tax system, is to include all real economic income in the income tax base. In this way, the goals of low marginal tax rates and horizontal equity (i.e., similarly situated taxpayers bear similar tax burdens) can be most fully realized.

Nevertheless, the tax system also is used to encourage taxpayers to undertake preferred behavior, such as the provision of retirement or medical benefits, that effectuates a specific social goal. Some tax incentives are directed toward encouraging individual taxpayers to undertake the preferred behavior for their own benefit, and other incentives are directed at encouraging entities (such as employers or insurance companies) to undertake the preferred behavior for the benefit of groups of individuals.

It is inevitable that the favorable tax treatment for certain types of behavior will be consistent with the goals of low marginal tax rates and horizontal equity. On a policy level, this is justified by the achievement of the social objective. Thus, it is important to condition the favorable tax treatment on the satisfaction of rules (e.g., qualification rules) that assure that the objective is achieved in any particular situation.

The primary social objective justifying the exclusion of employer-provided welfare benefits from income is the receipt by low- and middle-income employees of certain essential social services, such as health insurance. Nondiscrimination rules are crucial to the attainment of this objective. The theory of the nondiscrimination rules is that highly compensated employees will arrange to have the employer provide them with tax-favored welfare benefits and, through the operation of the nondiscrimination rules, the low- and middle-income employees also will receive the tax-favored welfare benefits.

Some commentators maintain that even though the purpose of excluding welfare benefits from income is to cause the actual provision of certain services to low- and middle-income employees, the role of the nondiscrimination rules should be solely to assure nondiscriminatory availability of tax-favored welfare benefits. If nondiscriminatory availability were the exclusive goal, however, the best approach, consistent with the goal of horizontal equity, would be to allow individual taxpayers to deduct the cost of certain services, such as health insurance, so that tax-favored treatment would not depend on whether one's employer adopts a benefit plan.

The individual deduction approach to favorable tax treatment for welfare benefits generally has not been adopted, partly because it would not result in sufficient utilization by low- and middle-income individuals. In addition, actual receipt of the benefit, not individual choice, is the social objective. (The relatively low level of participation in individual retirement accounts (IRAs) by low- and middle-income individuals not covered by a qualified plan provides some indication of the utilization rate under an individual deduction approach.) On the other hand, by essentially restricting the favorable treatment to benefits provided under employer-maintained plans and imposing nondiscrimination rules based on actual receipt of benefits, the tax code requires employers that wish to provide tax-favored benefits to their highly compensated employees to ensure that their nonhighly compensated employees receive comparable benefits. Of course, rejection of the individual deduction approach does not mean that nondiscriminatory availability is not important from a policy perspective, only that it is not sufficient to justify the favorable tax treatment of welfare benefits.

**Basic Structure**

**75 Percent Average Benefit Test**

Given the policy decision to target favorable tax treatment at employer-
maintained plans, the threshold issue for Congress was to select the type of nondiscrimination test that most effectively achieves the policy objective. A simple approach would be to provide that a welfare benefit plan is discriminatory unless it covers all (or a very high percentage) of the employer's employees. Another approach, somewhat more flexible, was suggested in the president's tax reform proposal. Under this approach, each separate welfare benefit plan generally would be required to cover a nondiscriminatory classification (i.e., fair cross-section) of the employer's employees. Still another approach would condition the availability of favorable tax treatment on the provision of a minimum benefit, defined by statute or regulations, to an employer's low- and middle-income employees.

The basic approach chosen in the Tax Reform Act is more flexible than these approaches. Essentially, it requires that the average benefit actually provided to nonhighly compensated employees be comparable to the average benefit provided to highly compensated employees. Under the act, 75 percent is deemed to be sufficiently comparable to justify the favorable tax treatment. For purposes of this test, all benefits covered by the same code section generally are treated as of the same type and are aggregated. Thus, all health benefits generally are aggregated for purposes of applying this test.

Unlike certain other possible approaches, the adopted approach generally gives an employer credit for all benefits of the same type provided to its nonhighly compensated employees, even if such benefits are provided under a different plan and are less valuable than the benefits provided to most of the highly compensated employees.

For example, assume that an employer makes available to all of its employees two plans, one of which (Plan A) has a value of $1,250 per covered employee and requires an employee contribution of $250, for a net subsidized benefit of $1,000. The second plan (Plan B) has a value of $1,000 per covered employee and requires an employee contribution of $200, for a net subsidized benefit of $800. Assume further that all of the highly compensated employees elect Plan A and all of the nonhighly compensated employees elect Plan B. Under these circumstances, Plan A would fail both the test under the president's proposal and the simple test requiring that a plan cover all or substantially all of the employer's employees. However, Plan A does not violate the 75 percent test, because for this purpose, it is aggregated with Plan B, and, overall, nonhighly compensated employees receive an average benefit that is 80 percent of the average benefit received by the highly compensated employees.

For purposes of the 75 percent test, the term "benefit" generally refers to the insurance coverage, and not to the services, claims, or reimbursements provided under the coverage. Accordingly, the average benefit that is measured under the test is the average value of the coverages actually provided to the employees.

90/50 Percent Availability Test
The test—Under the 90/50 percent test, 90 percent of the nonhighly compensated employees must have available to them a benefit equal to at least 50 percent of the largest benefit available to any highly compensated employee. This ensures that almost all nonhighly compensated employees will have a substantial benefit available. As with the average benefit test, all benefits covered by the same code section generally are aggregated.

Reasons for the test—Why did Congress provide a test in addition to the 75 percent average benefit test? The chief concern was that the 75 percent test reflected an averaging approach, and thus did not ensure that substantially all of an employer's nonhighly compensated employees would at least have a substantial benefit available to them. In other words, if the 75 percent test were the only test, there could be situations where a substantial number of nonhighly compensated employees could be excluded altogether (i.e., not only from actual coverage but also from eligibility). For example, if the average benefit provided to highly compensated employees was $1,000 and one-half of the nonhighly compensated employees received an average benefit of $1,500, the other half of the nonhighly compensated employees could be excluded altogether. Indeed, even if the nonhighly compensated employees who were provided a benefit received an average benefit of $1,000, a full 25 percent of the nonhighly compensated employees could be totally excluded.

It was believed, therefore, that the desired social objective would be better achieved if the average benefit test were not the only test. Even though broad availability was determined not to be a sufficient requirement because it did not sufficiently assure the actual receipt of benefits by low- and middle-income employees, broad availability certainly increases the likelihood that low- and middle-income employees will receive the desired benefits. Of course, the concern about availability would have been reduced if the comparability percentage under the average benefit test had been closer to 100 percent.

50 Percent Availability test
The test—At least 50 percent of the
employees to whom a plan is available must be nonhighly compensated employees. (See section 89(d)(2) for an alternative means of satisfying this test.)

Reason for the test—Why did Congress provide a test other than the 75 percent average benefit test and the 90/50 percent availability test? The primary reason was that without an additional test, an employer could provide a significant tax-favored benefit to all or a select group of the highly compensated employees (such as an executive-only health plan). For example, assume one base health plan with a value of $750 covers all of an employer's employees. If the 75 percent test and the 90/50 percent test were the only tests, the employer could establish a second plan with a value of $250 for each of the highly compensated employees and still satisfy the nondiscrimination test. To the extent that an executive-only plan covered less than 100 percent of the highly compensated employees, the $250 value could be increased up to $750 in some cases. Granting favorable tax treatment to such plans not only would have caused a revenue problem, but would have at least caused concern that the rules were insufficient to achieve the desired social objective, i.e., nondiscriminatory coverage of low- and middle-income employees.

80 Percent Coverage Test: Alternative to the Application of the 75 Percent Test, 90/50 Percent Test, and the 50 Percent Test
The test—At least 80 percent of the nonhighly compensated employees must be covered (not simply be eligible) under the plan.

Reason for the test—Why did Congress provide an alternative to the group of three tests described above? The concern was that certain employers, especially small employers, might have very simple benefit structures under which substantially all of the employees are covered under one plan or a few very similar plans. For those employers, the application of the three tests would be unnecessary since a single test could demonstrate the broad nature of the coverage.

Note—This is a simple test designed for employers with very simple benefit structures. It is expected that employers with many different benefit options rarely will be able to use this test.

Benefits Subject to the Rules
Health and life insurance benefits are subject to these new rules. An employer generally may elect to apply the new rules to group legal service plans, educational assistance programs, and dependent care assistance programs. One advantage of such an election is that an employer may combine such plans with group-term insurance plans to satisfy the 75 percent test. Such aggregation is permissible without regard to whether the plans are part of a cafeteria plan.

Definition of a Plan

Definition—Each different benefit option is a different plan. Thus, each different HMO and each different indemnity option is a different plan.

Aggregation

75 percent test and 90/50 percent test. After each plan has been separately valued, generally all plans under the same Internal Revenue Code section are aggregated for purposes of the 75 percent test and the 90/50 percent test.

50 percent test and 80 percent test. Health plans of comparable value may be aggregated for purposes of the 50 percent test and the 80 percent test.

Comparable value. In general, plans are of comparable value (and thus may be aggregated for purposes of the 50 percent and 80 percent tests) if the value of the less valuable plan is at least 95 percent of the value of the more valuable plan.

Reason for the definition—There is little alternative to defining each option as a separate plan. If a plan were defined, for example, as all benefits provided under a single document, highly compensated employees could be covered under a generous option and nonhighly compensated employees could be covered under a meager option without violating the rules. Also, although some employers will technically have many different plans, the aggregation rules will reduce this burden tremendously.

Valuation

Health benefits—Treasury is to prescribe a table showing the relative values of different types of health coverage based on attributes such as deductibles and copayments. The table will also prescribe a means of determining the amount of the income if a plan is discriminatory.

Life insurance—For discrimination testing purposes, valuation is made age-neutral by assuming all employees to be age 40. Generally, life insurance benefits may vary in proportion to compensation, and a valuation technique is provided to accomplish this. If a plan is discriminatory, these special valuation rules do not apply, and the employee is taxable on the discriminatory excess at the higher of the table cost or actual cost.

Special Rules

Line of business—The nondiscrimination rules may be applied separately to separate lines of business or operating units. Treasury will prescribe rules and guidelines for determining whether purported lines of
business or operating units will be recognized. In certain cases, an IRS determination may be a precondition to recognition.

Excluded employees—Certain employees are excluded from consideration in applying the nondiscrimination rules. In general terms, they are (1) new employees, (2) part-time employees, (3) seasonal employees, (4) employees under age 21, (5) union employees, and (6) nonresident aliens. Specific definitions are provided in the statute. However, generally, employees in an excludable category may not be excluded with respect to a plan if other employees in the same category are eligible under any plan of the same type (i.e., providing benefits excludable under the same Code section). There is also a rule providing generally that employees who normally work less than 30 hours per week but are not excluded as part-time employees may receive less valuable health benefits than other employees working at least 30 hours per week.

Subjective rule—Some forms of discrimination are not detectable by objective tests, such as in the case of a plan that covers only a rare condition to which only the owner of the employer is subject. There is a subjective nondiscrimination rule to prohibit this unusual type of discrimination.

Family rules and coverage from another employer—In general, an employer may elect to disregard, for purposes of applying the 75 percent test to health plans, any employee or family member of an employee if such individual is covered under a core health plan of another employer. There are also rules regarding testing family coverage separately and solely with respect to those employees who have families and regarding the evidence required to show who has coverage elsewhere and who has families.

Note—The rules involving the determination of who has other health coverage and which employees have families are elective. For many large employers, it may not be advisable to make the election to use these rules.

Qualification Requirements

A plan must be in writing, legally enforceable, intended to be maintained indefinitely, for the exclusive benefit of the employer's employees, and must provide reasonable notification to employees. These requirements apply generally to all employee benefits, not simply to those subject to the new nondiscrimination rules.

Sanctions

Discriminatory excess—If a plan fails the nondiscrimination rules, the discriminatory excess is included in the income of highly compensated employees.

Qualification—If a plan fails the qualification rules, the services provided or claims proceeds (rather than the insurance coverage) are includible in the income of all employees.

Failure to report—If an employer does not timely report includible employee benefits on a W-2, the employer is liable for a penalty tax unless the failure is due to reasonable cause. The tax is equal to the highest individual rate multiplied by the entire benefit of the employees whose benefits were not reported (even if only the discriminatory excess had to be reported). This penalty tax applies in addition to any other applicable penalties or interest.

Legislation and Litigation

Legislation

Catastrophic Care

Legislation expanding coverage for catastrophic care got a boost from President Reagan January 27, who said in his State of the Union Address: "Let us remove a financial specter facing our oldest Americans—the fear of an illness so expensive that it can result in having to make the intolerable choice between bankruptcy and death. I will submit legislation shortly to help free the elderly from the fear of catastrophic illness."

The vagueness of the Reagan statement prompted congressmen and senators, at separate hearings in the House and in the Senate, to query Health and Human Services (HHS) Secretary Otis Bowen on the likely content of such legislation. Bowen's testimony made it clear that the recommendations he has previously made to the president do not have the administration's wholehearted support. In fact, at this stage, the administration is still considering legislative options being advanced by those in the administration who oppose Bowen's proposal to provide catastrophic coverage for acute care expenses of the elderly by expanding Medicare and imposing an additional $4.92 premium on beneficiaries (see December 1986 Employee Benefit Notes). Reports surfaced of an administration option to cap out-of-pocket expenses of the elderly for acute care at $15,000, instead of the $2,000 cap recommended by Bowen. The higher cap is intended to leave a greater role for private insurance.

At a January 29 speech before the National Press Club, Bowen was asked why his proposal to expand Medicare coverage failed to include coverage for long-term care. He described long-term care as an issue that is "very difficult, very complex, that can't be immediately done without a vast infusion of funds."
In other words, federal policy toward long-term care will require much more time to develop.

In the meantime, congressional sponsors are anxious to pass some kind of catastrophic legislation, although they are far from agreement as to what that would actually entail. House members on the Ways and Means Health Subcommittee, including Reps. Pete Stark (D-CA) and Willis Gradison, Jr. (R-OH), predicted that a bill would be passed in 1987. In the Senate, Sen. Edward Kennedy (D-MA) has introduced legislation modeled on the Bowen report. Other Senators on the Finance Committee, including its Chairman Sen. Lloyd Bentsen (D-TX), would support catastrophic protection for the elderly, although leading senators are still stymied as to appropriate action for long-term care.

**Congressional Staff Outline Health Agenda**

Key congressional staff members discussed the legislative health care initiatives most likely to see action by the new Congress during a January conference sponsored by the Washington Business Group on Health and the National Association of Manufacturers in Washington, DC.

*The View from the House Side—Diana Jost of the House Ways and Means Health Subcommittee said two major areas of concern will be catastrophic care and budget reconciliation, particularly in light of the proposed Medicare cuts included in President Reagan's budget proposal for fiscal year 1988. As in previous sessions of Congress, health care legislation will be incorporated into omnibus budget bills because, said Jost, Congress tends to focus on health care issues primarily within the context of the federal budget deficit.*

Jost predicted a top priority will be development of a bill to provide a catastrophic health care benefit through Medicare. A subcommittee proposal probably would be similar to the one advanced by Health and Human Services (HHS) Secretary Otis R. Bowen, but with lower beneficiary cost sharing. The benefit could be financed in any of several ways, Jost said, including requiring all state and local government employees to pay the Medicare Hospital Insurance payroll tax, taxing beneficiaries for all or part of the value of their Medicare benefits, increasing the cigarette tax, or charging Medicare beneficiaries an additional monthly premium.

Peter Budetti, counsel for the House Energy and Commerce Health and Environment Subcommittee, said the subcommittee will tackle the problem of how to provide health care for homeless people. He also predicted the proposal by HHS to repeal the equal contribution requirement of the 1973 HMO Act will meet resistance because the proposal would "emasculate" the law by permitting employers to opt not to contribute toward employees' HMO coverage.

The subcommittee also will hold hearings on insurer profitability as it examines medical malpractice tort reform options. Other areas of interest include the banning of cigarette advertising; stepping up medical research, particularly with regard to the acquired immune deficiency syndrome (AIDS) and sexually transmitted disease; improving health care for pregnant women and children; and possibly separating Medicaid from the welfare program.

A primary effort of the Labor-Management Subcommittee of the House Education and Labor Committee will be the Family Medical Leave Act, which will be reintroduced during the 100th Congress, said majority counsel Fred Feinstein.

While acknowledging that the bill would, in a sense, mandate benefits, Feinstein maintained that the committee generally does not favor requiring employers who already offer benefits to do more. "Employers who provide a social good shouldn't be penalized," Feinstein said. However, the bill has a place in a long tradition of labor law, said Feinstein, including minimum wage requirements, regulation of overtime and child labor, and the Social Security Act.

Interest in the bill will be enhanced by the U.S. Supreme Court's recent ruling upholding the constitutionality of a California law mandating that employers grant up to four months of unpaid leave to pregnant women and provide reinstatement after they return to the work place. (See January 1987 *Employee Benefit Notes*, for more about *California Federal Savings and Loan v. Guerra*.)

*From the Senate Side—Congress will seek a balance between expanding the role of employers in financing health care and enhancing the competitiveness of U.S. firms abroad, said David Krawitz, legislative assistant for Sen. Donald Riegel (D-MI) of the Finance Committee. (For more about the challenge facing Congress, see January 1987 EBRI Issue Brief.*)

Riegel has introduced a bill (S.177) to require states to establish pools to finance care for the uninsured. Hospitals would contribute to the pool through a tax based on gross operating revenue and would be reimbursed for uncompensated costs at the end of each year.

David Nexon, health staff director for the Senate Labor and Human Resources
Committee, chaired by Sen. Edward Kennedy (D-MA), identified four major areas that will receive the committee's attention: (1) minimum health insurance coverage that all employers would be required to provide; (2) catastrophic coverage for Medicare recipients, going beyond the proposal submitted by HHS Secretary Bowen to also include coverage for prescription drugs, mental health and substance abuse treatment, and special assistance for low-income elderly; (3) improving research and treatment for (AIDS); and (4) ensuring adequate health care for children and expectant mothers, particularly those in low-income families.

Bruce Kelly of the Finance Committee Subcommittee on Health said he perceives virtually no sentiment among committee members toward taxing employee health benefits. The committee regards quality of care as a major priority, he said, and may advance legislation to improve nursing home quality assurances, perhaps based on a study last year by the Institute of Medicine.

Regulations
IRS Issues More Tax Reform Guidelines

The Internal Revenue Service (IRS) has issued guidance on certain provisions of the new tax law, including: annual limits on elective deferrals, qualified plan distributions, rollovers of partial distributions, estate tax deductions for sale of employer securities to ESOPs (see "Estimated Revenue Losses Soar for new ESOP Provision" on p. 1), and the transition rule treatment of certain lump-sum distributions (87-13); changes in rules for contributions to IRAs (87-16); defined benefit plan interest rates to be used in computing present values of plan benefits (87-20); and questions and answers on the new limits on qualified plan contributions and benefits (87-21). The IRS will continue to release guidance on the new tax law in a variety of forms, including press releases, notices, bulletins and regulations.

PBGC Issues Rule on Multi-employer Plans

The Pension Benefit Guaranty Corporation January 15 published final rules covering valuation of plan benefits and plan assets following mass employer withdrawal, and set the interest rates to be used in valuations. For more information, see the January 15 Federal Register, vol. 52, no. 10, pp. 1626-1627.

At EBRI

EBRI Congressional Briefings

EBRI is undertaking another series of congressional staff briefings, beginning

From the Record

[Editor's Note: The following remarks by John Erlenborn, a former member of Congress, appeared in the December, 1985 issue of The Pension Actuary, a publication of the American Society of Pension Actuaries. EBRI's April 27, 1987 policy forum is on "Government Mandating of Health, Pension, and Other Employee Benefits."]

"Enter (from stage left) the new genre of federal largesse, mandated benefits. Oh, we have had some mandates for years, but the new approach goes beyond that modest beginning. New laws and legislative proposals would have the employer providing access, and, in some cases, funding benefits for dependents of the employee and even the general public....

"Such proposals as [continuation of health care coverage] will continue to be put forward in the coming years. And as concern for retirees continues and grows, the lack of pension coverage in the small business sector will not be overlooked. Never mind that the tax incentives have been diminished, thus discouraging small business from providing pension benefits. As long as constituents have concerns, members of Congress will have proposals to meet those concerns.

"A mandatory Universal Pension System (MUPS) has been talked about in the past, but the principle of a voluntary system has proven too strong so far. MUPS could prove to be a serious proposal in the future. Not only would it provide an occasion for political profit when proposed and enacted, but it could help avoid political embarrassment in the future.

"Increases in Social Security old-age benefits are quite popular, especially in election years. But the cost can be reflected in payroll taxes which are paid by all workers. Increases in MUPS benefits cost the employer only. With a MUPS in place, more of retirement income could be mandated from the private sector with a diminishing reliance on Social Security which younger workers mistrust already.

The goal of reduced deficits and even a reduction in the national debt is one that most of us can and do endorse. But let us beware that it can also be an occasion for the need to be vigilant, active and vocal in defense of the voluntary private pension system."
with a program on "Employee Benefits after Tax Reform" on February 17. The program was led by EBRI President Dallas Salisbury, who discussed immediate effects of tax reform. He was joined by Emily Andrews, EBRI research director, and Robert B. Friedland, EBRI research associate.

Presentations

For the month of February, EBRI President Dallas Salisbury made a number of presentations. These included: "An Overview of Current Benefits Legislation" before the International Association of Personnel Women Legislative Conference Feb. 5; a speech before the National Investments Specialists Federation Feb. 6; remarks before the Southern Pension Conference Feb. 10; a presentation to the Washington Employee Benefits Forum Feb. 23; and a speech before the Financial Executives Institute Committee on Employee Benefits Feb. 28.


Emily Andrews, EBRI research director, presented remarks on "Employee Benefit Issues and the GAO" as part of a panel discussion at the Government Accounting Office's conference on Employee Benefit Plans on January 29.

Deborah Chollet, EBRI senior research associate, has been invited to serve on the Advisory Board for InterStudy's Center for Aging and Long-Term Care. InterStudy is a nonprofit health care research firm in Minneapolis, Minnesota. The Center for Aging and Long-Term Care is designed to identify and develop ways to organize, deliver, and finance health and long-term care for the elderly.

Announcements and Publications

Medical Care Costs Increase 7.7 Percent in 1986

Consumer prices rose 1.1 percent in 1986, according to the Labor Department's Bureau of Labor Statistics (BLS). The increase represents the smallest increase in prices for goods and services in 25 years. The medical care component, however, rose by 0.7 percent in December 1986, bringing the total annual increase in medical care costs to 7.7 percent for 1986. Increases in the cost of medical care and increases in other areas were offset by the 19.7 percent drop in energy prices.

Government Publications

Wage Withholding for Child Support: An Employer's Guide, Department of Health and Human Services

The Department of Health and Human Services (HHS) February 11 announced the publication of a handbook entitled "Wage Withholding for Child Support: An Employer's Guide." The handbook, in question-and-answer form, provides employers with necessary information about their responsibilities under the wage withholding provision of the federal Child Support Enforcement Amendments of 1984. The amendments mandate automatic wage withholding for all cases in which the obligated parent is employed and there is a delinquency equal to 30 days support. For copies of the guide, contact the National Institute of Child Support Enforcement, 5530 Wisconsin Ave., Bethesda, MD 20815. Bulk quantities can be ordered from the National Child Support Enforcement Reference Center, 6110 Executive Boulevard, Rockville, MD 20852.

Employee Stock Ownership Plans: Benefits and Costs of ESOP Tax Incentives for Broadening Stock Ownership, U.S. General Accounting Office

This is the third in a series of General Accounting Office (GAO) reports requested by former Sen. Russell B. Long. The report says that as of March 1986, there were about 4,800 active employee stock ownership plans (ESOPs) in the United States covering more than 7 million workers and holding nearly $19 billion in assets. ESOPs, the report says, "do appear to broaden the degree of capital ownership within sponsoring firms, but the small number of employees covered and the small percentage of all stock held by ESOP trusts put an upper limit on the extent of overall expansion of capital ownership in the United States associated with ESOPs."

Nongovernment Publications

Early Retirement Incentive Programs: Trends and Implications, Elizabeth L. Meier, AARP

In an economy shaped by global competition and continuing merger activity, short-term early retirement incentive programs are becoming an increasingly common way for employers to deal with the need for work force reductions, especially in large corporations that already have liberal
early retirement provisions in their pension plans, according to the author, who prepared this report for the American Association of Retired Persons (AARP). Meier notes, however, that despite the sweetened benefits and cash payments, participants may have economic losses not only in foregone wages, but in a decrease in the retirement benefit from that which would have been available at the normal retirement age. For a free copy, contact Public Policy Institute, Division of Legislation, Research and Public Policy, AARP, 1909 K Street, NW, Washington, DC 20049. (202) 872-4700. Request study no. 8604.

Surveys

Blue Book Digest of PPOs, National Association of Employers on Health Care Alternatives

The National Association of Employers on Health Care Alternatives (NAEHCA) has published the second edition of its "Blue Book," which contains information on 462 preferred provider organizations (PPOs) in 43 states, the District of Columbia, and Puerto Rico. This is, according to NAEHCA, "an unprecedented increase of over 130 percent since November of 1985, when the first Blue Book listed approximately 200 PPOs in 34 states." According to the Blue Book, California, Florida, and Texas lead the nation in the number of PPOs located in those states. Listings in the book include the profit status, the number of physicians, the number of hospitals and the number of member groups in the PPO. Contact NAEHCA, 104 Crandon Boulevard, Suite 304, Key Biscayne, FL 33149. (305) 361-2810. Cost $54.50.

AMA Surveys of Physician and Public Opinion, Lynn Harvey, Stephanie Shubat, American Medical Association

The latest in a series of surveys conducted by the American Medical Association (AMA) over the last ten years, this report summarizes recent results and compares them to previous findings. Among those findings are: most doctors believe that they are losing control over patient decisions in hospitals, and many for the first time see professional liability as the main problem facing medicine. In addition, the survey found that a majority of Americans believe Medicare payments should be based on patient income and would be willing to pay additional taxes to ensure the program's continuation. The survey was based on telephone interviews with 1,000 physicians, and with 1,510 members of the general public. Limited copies are available at no charge from the Issues and Communications Research Department, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610. (312) 645-4430.

Retiree Life and Health Coverages Represent Large Potential Liability, Charles D. Spencer and Associates

Life insurance and health benefits for retirees may present a large potential liability, according to a survey of 155 corporate annual reports by Charles D. Spencer & Associates, Inc. This issue recently received wide attention in Congress and the press with LTV Corporation's attempt to discontinue such benefits. The survey describes disclosures of the 130 companies that supplied data, showing that few of the companies prefund their retiree coverages. For a free copy of the survey, contact Charles D. Spencer & Associates, Inc., 222 West Adams, Chicago, IL 60606. (312) 236-2615. Ask for no. 328.03.-7.

Employee Retirement and Insurance Benefits Cost Survey, Teachers Insurance and Annuity Association College Retirement Equities Fund

This is the fifth report in the biennial survey series instituted by Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF) in 1977 to provide standardized annual comparative information on expenditures by colleges and universities for employee retirement and insurance benefits. With this information, institutions may assess their retirement and insurance plan costs in relation to those of other institutions that are similar in type (based on type and complexity of program offering), geographic region, or size. Contact TIAA-CREF, 730 Third Avenue, New York, NY 10017. (212) 490-9000. Cost $4.50 each, postpaid.

Survey of the Funded Position of Multiemployer Plans, Martin E. Segal Company

The funded position of multiemployer defined benefit pension plans improved significantly over the past year. This is the primary finding of the Martin E. Segal Company's fourth annual survey. Of the plans surveyed, 80 percent were fully funded for their vested benefits—a 7 percent increase over last year. In addition, the average percent of vested benefits that were funded by plans increased a full percentage point, to 95 percent. For a complimentary summary of survey results, contact Deborah L. Bohren, Director of Public Affairs, Martin E. Segal Company, 730 5th Avenue, New York, NY 10019. (212) 586-5600.
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The report supplements the financial data with a review of legislative and regulatory issues affecting private- and public-sector pension plans. Changes in issues such as asset reversion, performance fees, use of soft dollars, fiduciary liability and others can affect the rate of accumulation of pension assets, the level of net contributions and the manner in which the funds are managed and invested.

The EBRI Quarterly Pension Investment Report is necessary reading for plan managers, investment advisors, plan sponsors, and anyone else interested in the growing pool of pension funds. This report is available only to EBRI sponsors. For information on becoming an EBRI sponsor and receiving the NEW EBRI Quarterly Pension Investment Report, please complete the form below.

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